

REQUEST TO REMOVE SERVICES FROM WAIT LIST

CONSUMER NAME: _____

DMH ID#: _____

DATE: _____

SC NAME: _____

SERVICE BEING REMOVED: _____

CHOOSE REASON FOR REMOVAL:

- ☐ Consumer no longer requests to be on the wait list
- ☐ Death
- ☐ Discharged
- ☐ No Waiverable Diagnosis
- ☐ Not Medicaid Eligible/Waiver Eligible
- ☐ MRDD Waiver Slot Approved
- ☐ Services Authorized or Provided

ADDITIONAL INFO: _____

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ADDITIONAL INFO: _____

Removed from CIMOR Wait List by: _____ Date: _____